COMMENT

The few who developed skin reactions were cleared up by intravenous nictinic acid and the local use of sulphathiazole ointment. In some few cases, we had to discontinue the tryparsamide and resort to other arsenicals, such as mapharsen.

Many of the patients did not show much improvement for six months. Most of the cases, where there was optic nerve involvement, went on to blindness, but two cases showed marked improvement. A constant check was maintained to show any signs of beginning blindness, but we were never able to determine that tryparsamide was to blame for the damage.

We are trying to improve some of the tabes dorsalis patients by the intraspinal use of glucose and nicotinic amide, and thus far they are improving, but the experiment has not been carried on long enough to be sure of results.

Most of the cases which show cardiac disturbances following malaria react well to strychnine given twice a day, orally.

We kept as many of our patients as would stay, for four months, and seldom allowed one to go under three months. Many of them stay for the entire course of treatment.

It is impossible to maintain contact with all of the cases, but a number are employed locally and others write us telling how well they get along. Of those working locally we have examined a number, and they seem to remain well and are able to work in shipyards. The kneejerks were normal, the pupils reacted, and they were free from tremors; but we found that those who had marked speech defects were apt to have some residuals of the speech defect.

We did not follow any set routine, but endeavored to vary the method to suit the individual; and we feel that the results are in part due to our complete control of the case during treatment.

The patients were, as a rule, very coöperative as soon as they realized the gravity of the disease and the results of not continuing after-care. All of these patients react badly to alcohol, and will not be able to get along well if they use any alcoholics, even after they leave the hospital.

We were able to train our employees so that they understood the treatment, and to the faithful work, interest and pride of a deed well done by these attendants we owe much of our success.

Our superintendent, Dr. Margaret Smyth, gave us her entire coöperation, and, by her interest, enabled us to carry on the work in spite of the difficulty arising from war restrictions.

Stockton State Hospital.

REFERENCES

1. Kidd, J. D., and Friedewald, W. F.: Proc. Soc. Exp. Biol. and Med., *47*, 127, 1942, Jour. Exp. Med., *76*, 543, 557 (Dec.), 1942.

2. Henle, W., and Chambers, L. A., Science, *92*, 313, 1940.

PRACTICAL ETHICS*

Louis J. Regan, M. D., LL.B.
Los Angeles

IT has been said that ethics was formulated and developed by the weak to protect themselves against the strong. Perhaps it is desirable to attempt to counteract the predatory instinct which evolution has not, as yet, eliminated from most of us. The word ethics is derived from the Greek "Ethos," meaning custom, usage, character. By extension, as we use it, it means conforming to professional standards of conduct. The word practical is used in this discussion to mean "manifested in practice," as opposed to theoretical, ideal, or speculative.

We may set up various codes of ethics and memorize them, but they are valuable and useful only to the degree in which we succeed in manifesting them in our contacts and relationships. What price ethics if we accept the principles and act upon them only to a certain point or with certain groups, dispensing with them in so far as other groups are concerned.

PRACTICAL ETHICS: ITS CONNOTATION

Practical Ethics refers to the part of our codes of ethics that we actually adopt and use, because we have found it desirable and advantageous, in one way or another, to do so; because, for example, we have found that the way is made smoother; our contact with others, the public, our patients, our colleagues, is made pleasanter. In so far as we have recognized ethics to be practical it is not difficult to abide by the rules. It is otherwise as to principles that remain abstract and theoretical, or as to those parts of the Code which are, in our observation, unfortunately so generally disregarded or infringed upon. I believe, however, that the code of ethics to which we have subscribed is essentially sound in principle, and in very large measure practical. To some extent we can determine its practicability in observing the results which follow the disregard and abuse of some of its principles. This is particularly and strikingly illustrated when we consider the results which follow disregard of the principle which holds that we must not, unethically, criticize our fellow practitioners. I am sure that you will agree with me that no principle of our code of professional conduct has been, and is being so generally disregarded as this one. Why does one who is a member of a healing profession speak disparagingly of a fellow practitioner? Will we all agree that no physician can fairly and ethically criticize the work of another until, and unless, he is in possession of all of the facts of the case? Must he not have the physician's version as well as the story of the patient? Yet 90 per cent of all of our malpractice claims and suits are precipitated by the unwise comments or criticism of one physician in respect to the professional conduct of, or the results obtained by, another physician. In the

* Read in 1943, before several medical groups in Southern California.

great majority of these instances it is criticism by a succeeding doctor of his predecessor on the case. Does the one expect to expand himself at the expense of the other? What does it profit him? If the patient is intelligent, I can see no profit in it. On the other hand it seems to me that it tends to injure all concerned, the maligner, the malignee and the entire healing profession.

UNETHICAL CRITICISM: ITS RESULTS

The results indicate that unethical criticism is destructive; that medical prestige is lowered; the patient's confidence in the profession is undermined; and the reputation of the criticized physician is damaged.

The patient is encouraged, in fact may be led to bring an accusation of malpractice against the maligned and generally innocent practitioner. I say generally innocent advisedly, because 80 per cent of the malpractice claims made locally are unjustifiable; that is, 80 per cent of these claims are without merit. Thus the generally innocent defendant is further injured in reputation and prestige, in loss of time, and, all together, is subjected to a most unpleasant and harrowing experience.

HOW MANY MALPRACTICE CASES ARE BORN

Strict adherence to our ethical codes would eliminate a large proportion of the unjustifiable malpractice claims that now harass and torment us. A highly respected malpractice attorney of great experience, now deceased, used to say: "Malpractice cases are born in the offices of the succeeding physicians." The little progress we have made in discouraging condemnation of the other fellow makes it certain that if and when this observance becomes general, when this ethical principle becomes practical and functioning, rather than abstract and unapplied, the malpractice incidence will fall.

REPORT OF CASES

CASE 1.—Consider the recent case involving two physicians who practice as partners on the outskirts of Los Angeles. They have an equipment to administer x-ray therapy, and employ a technician. A patient presented an eruption on one of her hands. One of the partners, Dr. A, prescribed a course of x-ray treatments. These were administered by the technician. Some weeks later the patient returned to the office. At this time Dr. A was absent from the city. The patient was sent in to Dr. B, who was seeing her for the first time. Without giving the patient an opportunity even to state her name, Dr. B exclaimed: "Good heavens, woman, someone has certainly given you a terrible x-ray burn." The punishment fitted the crime this time, Dr. B being equally liable with his partner for the negligence of their employee.

Of course, the above case presents a striking and unusual illustration of destructive criticism based on too little information. It is probably true that a criticising physician isn't often motivated by malice. He may be talking thoughtlessly, or when in an egotistically expansive mood. But the damage is usually just as great as though he were acting maliciously. It isn't necessary for destructive criticism to reach such a point as to ask the patient, "Who butchered you?" or "Didn't you know better than to go to such a man?" Just the lifting of an eyebrow has been sufficient to precipitate a malpractice action. And, too, suit has resulted from the attempt, occasionally even the unintelligent attempt, on the part of the succeeding doctor to justify himself by throwing an onus on the doctor who previously cared for the patient. Consider the following case:

* * *

CASE 2.—A diagnosis was made of carcinoma of the sigmoid. Dr. A operated. Extensive envolvement was found and the patient did not stand the operation very well. A colostomy only was done. Dr. A advised the family that no more could have been done at the time without seriously endangering the patient's life, and that it was very doubtful if radical surgery would be advisable at any time. Three months later Dr. B undertook radical resection. The patient died. Dr. B said that everything would have been alright if Dr. A had performed the operation three months earlier, as he should have done, and as he, Dr. B, would have done had he had the patient at that time.

The patient's family immediately threatened Dr. A, demanding compensation. However, with the passage of time, having had opportunity to give further consideration to the facts, the family seem now to have concluded that Dr. B should be sued instead of Dr. A. It would appear that if a case exists at all, it is against Dr. B.

In the case just cited, Dr. B did not contact Dr. A or have any knowledge of the case other than that obtained from the patient. As a matter of practical ethics, should not a succeeding physician, for the benefit of the patient and for his own protection, obtain any available information from a preceding doctor? I would earnestly recommend it. If in particular circumstances it is difficult to contact the preceding doctor, or to secure his coöperation, it is not unlikely that a liaison can be set up through your Committee on Medical Defense.

THREE CONSTRUCTIVE PROCEDURES

In this connection it is suggested that utilization of the procedure outlined in the following three paragraphs would be constructive:

1. When a patient, especially one expressing dissatisfaction with treatment, progress or result, discontinues treatment while treatment is still necessary, a letter should be sent to the patient incorporating the pertinent facts, and recommending that further treatment be had. A carbon copy of the letter should be filed with the medical case record, and the facts should immediately be reported to the Committee on Medical Defense.

2. When a succeeding physician undertakes the care of a patient who has left the care of a prior physician under circumstances as set forth in paragraph 1 above, the succeeding physician should advise the Committee on Medical Defense.

3. The simple fact that Dr. A is treating or has treated patient B is not information protected by the Privileged Communications Statute.

Obviously, if no knowledge of a potentially dangerous situation comes to hand there is nothing that anyone can do to quiet the troubled waters. On the other hand when, because of information received, it becomes possible to investigate the circumstances out of which a claim is threatening to arise, the facts are obtained before they crystallize unfavorably, before a succeeding physician has committed himself to a position possibly antagonistic to the preceding physician.

COMMENT

It is surely a matter of practical, and for that matter of ideal ethics to protect a fellow practitioner. It is understood, of course, that the purpose and practice is not to defeat any legitimate claim of any patient, that the intent is not to whitewash any doctor who has ignorantly or negligently injured a patient. In seeking to be relieved of unjust accusations of malpractice, we do not seek to work an injustice upon a patient.

Many cases, the number constantly increasing, might be cited to illustrate the effectiveness of the early reporting of threatening situations. Physicians have constantly been urged to report immediately when it is learned that any patient is contemplating a malpractice claim against any doctor.

No practitioner can obtain good results in every case. No inference of negligence arises out of the fact alone that an untoward or an unexpectedly bad result follows treatment. If such were not the case every tombstone would serve as a perfect foundation for a malpractice action. But a patient, disappointed and unhappy because not cured or even improved, is inclined to blame his professional attendant. In fact, in this area, the people seem to have been educated to blame the doctor for any undesirable result. Not uncommonly a disgruntled patient makes the rounds endeavoring to find a doctor who will aid in supporting a malpractice claim. As the patient relates his story to the succeeding doctor it may truthfully appear that the preceding doctor has followed some procedure that the succeeding doctor, himself, would not have utilized. It must be borne in mind, however, that what a particular physician would or would not do is not the standard.

ON DIFFERENCES IN PROFESSIONAL OPINIONS

There are few conditions in which there is available a sole and specific remedy or procedure. There is usually a great latitude for honest difference of opinion, and it is often a matter for the exercise of the best judgment of the attending physician to decide which method he will use. He may later wish he had selected another, and in retrospect perhaps a better, method; but the physician must act without the benefit of hindsight. A physician is not required to follow a particular procedure. He is justified in his conduct of a case if the method employed is such as would be approved by even a respectable minority of his confreres in the same locality.

The succeeding doctor may be a specialist in the field or otherwise possess unusual skill and knowledge far beyond the average reputable practitioner. The standard, it is pointed out, is measured by the knowledge, skill and care of the ordinary reputable practitioner in the same general field of practice in the same community at the time in question. Practical ethics requires, as does the law, that we fulfill our duty to our patients, that we recognize and fully meet our responsibilities by undertaking to care only for those cases that are well within our capabilities; by conscientious study and investigation of the problems of each case, utilizing any and all indicated laboratory aids; by keeping abreast of the times and adopting approved methods of practice; and by acting toward every patient with the utmost good faith, recognizing that the physician-patient relationship is one of trust and confidence.

MALPRACTICE: AS A DISEASE OF THE SOCIAL BODY

Malpractice may be regarded as a sort of disease of the social body, endemic if not epidemic in distribution. The chief predisposing factor is ethical instability or deficiency. In one sense malpractice may be said to be contagious; the winning of an action by a patient invariably causes a temporary increase in the number of claims.

The intensified competition and the economic stress of the last two decades, the breakdown of the traditional general-practitioner-patient relationship, and the increase in "suit consciousness" due to the large number of personal injury actions partially explain the high malpractice incidence. Another factor which probably stimulates malpractice suits is the fact that they are difficult to defend. Several conditions are responsible for this. In the first place the physician is often unnecessarily vulnerable. The average physician is peculiarly naïve in some respects. Apparently he cannot believe that his patient, for whom he is doing his best and in whose welfare he is sincerely interested, will turn on him; thus, not anticipating the likelihood of a suit, he fails to take necessary precautions which would assure him of the best possible defense in the event of suit.

Again, as is too often the case, there is too great delay in the investigation of claims; and this, as has been pointed out, is disadvantageous to the defense. Finally, most cases are heard before juries made up of lay persons. It is a truism that no one can say what a jury will do. This is particularly true in respect to malpractice cases. Certainly lay jurors cannot be expected to understand complex medical facts. How do they arrive at a decision in these cases when two expert witnesses say that the defendant's conduct of the case did not meet the required standard, and two others say that what the defendant did was consistent with the usual and ordinary practice in the community?

PREVENTION IS THE BEST DEFENSE

Prevention is the best defense against malpractice. Making our ethics practical is an important,

if not the most important factor, in the prevention of unjustifiable malpractice claims. It is basic, of course, that the practitioner, if he is to avoid actual malpractice, must care for every patient with meticulous attention to the requirements of good practice. Bitter experience has taught us, however, that this does not ward off the unjust accusation and that no practitioner is immune. It is essential to be in a position to prove that the standard demanded by the law has been met in every case. Ideal case records are a bulwark. Obviously, the practitioner rarely has anyone who can testify in support of his contentions, but good records, office and hospital, go a long way in supporting his statements. Also the use of a consultant gives great protection. It is desirable to have a consultant see every patient who is not doing well or who is complaining or expressing dissatisfaction. When a consultant has seen the patient during the critical period, his testimony given in court has tremendous force. Practitioners would do well to give routine protective consultations, one to the other, whether or not a consultant's fee is available in a particular case. Practical ethics might well comprehend such a plan. It would not be undesirable in the interest of the patient, and it would give protection to the practitioner.

CASES IN ILLUSTRATION OF PRACTICAL ETHICS

A number of cases are cited which illustrate the value of practical ethics and the injury suffered by practitioner, patient and public, alike, when ethical principles are disregarded or abused.

REPORT OF CASES

CASE 3.—This was a case of external and internal hemorrhoids, and prolapse of the anus. The patient was operated. Following the surgery, a "whistle" tube was placed in the rectum. It consisted of a ⅜-inch rubber tube about 5½ inches long, wrapped in the middle 4 inches with vaselined gauze to a total diameter of 1 inch to 1¼ inches. The tube was not anchored. Castor oil was administered on the fourth day, but, contrary to written orders, the eliminations were not checked, and it was not known whether the tube had been passed or not.

The patient's wife was advised as to the possibility of the tube remaining in the body of the patient.

The operating physician was discharged from the case within a few days after the patient left the hospital, and another physician called in. The patient's wife stated, on the witness stand, that she told the second physician about the uncertainty in regard to the drain tube. About ten days later the patient was reoperated, in another hospital; hemorroids were removed, but the tube was not seen.

Four weeks after the second operation, the tube presented at the anus, when the patient strained at stool. It was removed next day, by the second operating physician.

The first operating physician was sued on the theory that he did not follow good practice in using the "whistle" tube, and that he was negligent in failing to remove it, and in not determining whether it remained in the body. There was no allegation of unskillfulness or of negligence in the performance of the surgery. Judgment was given in favor of the physician.

Comment.—The second physician in this case did not contact the first physician to ascertain the prior condition and what had been done; nor did he ask to see the hospital record covering the first hospitalization of the patient. It is suggested that he should have done so in the interest of the patient and that, had he done so, there might have been no suit in the case.

* * *

CASE 4.—The patient was engaged in putting asbestos covers on metal pipes, clamping the covers to the pipes by means of metal bands. He fell from a scaffold while holding one of the metal bands grasped in his clenched hand. His thumb was dislocated and, when his hand was opened, it was found that he had sustained an oblique laceration across the palmar surface of the little finger, beginning slightly above the base of the little finger upon the radial side and ending approximately at the base of the little finger on the ulnar side.

The injured hand was wrapped in some gauze, and the patient went to the office of the company's physicians.

The wound was found to be slightly irregular, with some maceration of the margins. A diagnosis was made of severance of the profundus flexor tendon. The tendon sheath was found, but the proximal end of the tendon was not, although, to permit further search, an incision of an inch to an inch and a half was made at the end of the original laceration, on the ulnar side, extending proximately along the ulnar margin of the palm. Approximately an hour was spent in the treatment, which included surgical cleansing of the parts, induction of novocaine anesthesia, debridement of the wound, making additional incision, search for tendon, and application of dressing. At the end of the period of unsuccessful search the physicians concluded that the patient should be hospitalized and so notified the compensation carrier. Upon being so instructed, the physicans sent the patient to a hospital and they, thereafter, had no part in the treatment of the patient.

At the hospital, the patient, now under the care of a second group of physicians, was put to bed, under observation. It was decided that no further incisions should be made in order to locate the profundus tendon, but that secondary tenorrhaphy would be done. A severe tendon sheath infection developed, necessitating a series of incisions to evacuate pus and produce drainage. The final result is a hand with practically no function, with the little finger amputated and with marked contracture of all of the flexor tendons.

The patient sued all of the doctors who treated him, the first group as well as the second. Conflicting testimony, more or less typical of all these cases, was presented in court. The patient testified that his hand was not even washed by the first doctors, that these doctors did not scrub their own hands, but worked upon him coming directly from another patient, that the first doctors made other and different incisions; that, while in the care of the second group of doctors, no one even looked at the hand for days, that unpadded casts were applied so tightly that the flesh fell off, that even after weeks in the hospital and after a series of operations, and after hot wet packs had been used for weeks, there was still asbestos on the hand, etc.

This case was in trial for 32 days; the jury were unable to agree upon a verdict.

INDUSTRIALLY INJURED PATIENTS

Not infrequently, an industrially-injured patient, after being treated for a time by one physician, is sent, by direction of a compensation insurance carrier, to another physician. From the malpractice angle, this practice creates a potentially dangerous situation. If the end result leaves something to wish for, and the patient is dissatisfied, he may bring suit against both the first and the second physicians who cared for him. Both physicians will be named in the action as codefendants. Every effort is then made by the plaintiff to manipulate the situation so that the two defendants become, in effect, adversaries. If successful, it is of course very satisfactory from the point of view of the plaintiff, but decidedly detrimental to one or both of the defendants.

In California and in a number of other states, an industrially-injured patient, although he has accepted a compensation award, may nevertheless have an action for malpractice against the physician who treated the injuries. The insurance company which paid the award will be entitled to reimbursement from any judgment recovered.

It is important under a set of circumstances such as those set forth in this case, that the records of all the physicians involved should be detailed and exact, and the principles of malpractice prophylaxis should be specially borne in mind.

* * *

CASE 5.—An Obstetrical Case. Normal gestation; normal delivery in hospital; normal puerperium while in hospital. Home on tenth day. Immediately began to flow. Gushing hemorrhage on twelfth day. Patient returned to hospital. Blood studies were made; red cell count, hemoglobin estimation, typing, etc. The patient was transfused and curreted with dull curret. No placental tissue found. Packed.

At this point the first physician was discharged. The succeeding physician moved the patient to another hospital. According to the hospital chart of the second hospital, a piece of placenta about 7 cm. across was found on the packing when it was removed. Nevertheless, the second physician thereupon curreted the patient. Following this, the patient ran a high spiking temperature and was very ill for a number of days. Treated with sulfa drugs and repeated transfusions. The first physician was sued on the theory that he had failed to remove all of the placenta. The second physician appeared as a medical expert witness for the plaintiff. The jury brought in a verdict in favor of the defendant physician.

Comment.—The succeeding physician took over this patient without contacting the first physician and, apparently motivated by the need to justify himself, declared that he took charge because action was necessary to save the patient's life. The bill he eventually rendered was, considering all the circumstances, excessively large. It was fortunate that the statute of limitations as applied to the succeeding physician had already run before the case against the first physician came to trial. In the opinion of some of the physicians who studied the case, if the patient had a justifiable complaint against anyone, it was against the succeeding physician.

The necessity of eliminating the unethical and dishonest practitioner, in order to safeguard the profession and the public, is obvious.

* * *

CASE 6.—This was a complex and most unusual case. A young woman, married about two months, presented herself with a history of not having menstruated since marriage; of having been nauseated for about one week, and of having had cramping pain in the lower abdomen for a few days. The onset of the pain was accompanied by spotting. A-Z was positive. Temperature normal, blood picture normal, except leucocytosis (16000). Examination disclosed uterus soft and enlarged to twice normal size. Marked tenderness to right. The examining physician believed that he made out a soft mass in the region of the right ovary and a smaller mass immediately adjacent to the uterus in the region of the right tube. The latter mass was exceedingly tender. A diagnosis was made of (1) probable cyst of the ovary, (2) possible tubal pregnancy, and (3) possible subacute appendicitis. Immediate operation was recommended.

At operation, according to the hospital record and the testimony of the operating surgeon and his assistant, there was found (1) cyst of right ovary, size of egg, (2) subacute appendicitis, and (3) a swelling of the right horn of the uterus, extending along the right fallopian tube for approximately 1½ inches. The swelling in the tube was about equal in size to the terminal phalanx of the thumb, but it decreased in size from uterus outward. It was testified that the operator picked the tube up in his fingers to examine it and that during palpation, it was seen and felt that some mass slipped into the uterus. Thereupon, the surgeon went in from below, while the abdomen was still open, and through the cervix removed a pregnancy sac intact.

Following this, the cyst and the appendix were removed. The operating surgeon testified that the postoperative progress was normal, other than that a low-grade infection, which developed in the wound, drained for several weeks. The patient testified that she thereafter menstruated normally for about six months, but that she had nausea; dragging pain in lower abdomen, some vaginal discharge, and that she lost weight. At the end of six months' period, she consulted another physician to whom she gave this history. He testified that, while his findings were consistent with endometritis, the uterus was normal in size. The patient did not return to him, but, two months later, consulted another physician, who, for purpose of identification, may be designated as Dr. X. Dr. X found the uterus soft and three times normal size; there was marked tenderness in the right adnexal region and the patient was flowing heavily and passing large clots. He made a diagnosis of endometriosis (endometritis?). A consultant, who was called in, confirmed the diagnosis. It was considered to be due to the original surgery, now interpreted as having been an incomplete abortion, (of what had been a normal intrauterine pregnancy). The patient was treated with sulfa drugs, diathermy and rest. The bleeding stopped and there was some improvement in the general condition. It is exceedingly interesting to note that the patient must have been pregnant during this time in view of later developments. It was observed that the uterus, while it seemed to decrease somewhat in size in the beginning of this course of treatment, soon began to enlarge. An A-Z was positive. The patient was in hospital for a brief period when she was approximately five months pregnant, apparently threatening to miscarry. When eight months pregnant, she went into violent labor. A caesarian section was performed on the diagnosis of threatened rupture of a uterine scar. The operative record states that there was

a "thin scar in the lower uterine segment," but the surgeon who performed the caesarian section testified that he had no independent recollection of a scar on the uterus. This operator did not contact the original operating physician or ask to see the original hospital records —and, in passing, it may be remarked that neither did Dr. X. Following the caesarian the patient made a good recovery, but the baby died. Dr. X and other physicians were now unable to find anything of an organic nature wrong with the patient. The tubes were found to be patent. The patient, however, remained underweight and complained of nausea, and pain and tenderness in the pelvis.

The first operating surgeon was sued. The charges were complex and multitudinous, but as finally developed during the trial, they were basically (1) lack of skill and care in diagnosis, (2) improper and unskilled surgery, and (3) unskillful and insufficient after-care. It was pictured to the jury, largely by Dr. X and the surgeon who performed the caesarian section, that the patient did not have the tubal pregnancy as described, that the products of conception could not have been displaced into the uterus, that had the patient presented a tubal pregnancy, something else should have been done, etc. Moreover, great stress was laid upon the presence of the scar in the lower uterine segment which, it was claimed, was due to the unskillful use of a curret in the hands of the first operating physician. The jury brought in a verdict in favor of the patient.

Comment.—Dr. X was responsible for the bringing of this action. There is no doubt but that he believed that this was a meritorious case. However, he erroneously believed that "sticking" the defendant in a civil malpractice action would result in eliminating him from the professional ranks. Such a result is not accomplished in this way. The local malpractice picture has been adversely affected, as the result of the vindictive prosecution of this case regardless of how idealistic Dr. X's motives may have been. The plaintiff and her attorney were undoubtedly influenced by Dr. X's attitude. This was manifested in their refusal to discuss settlement on a basis which the defendant could regard as reasonable. It may be stated that the amount awarded by the jury was less than the plaintiff might have had in an amicable settlement. Who, then, profited? A more constructive result might have been had for the patient, the public and the profession.

' ' '

CASE 7.—This was a wrongful death action brought by the decedent's heirs, his widow and son, against the defendant physician. A tonsillectomy was performed upon a man forty-odd years of age. Three days later the patient died. It was alleged that, at the time the operation was performed, the patient was suffering with Ludwig's angina and also, that the patient was an alcoholic, to the physician's knowledge, and should not have been subjected to surgery. The jury's verdict was in favor of the defendant physician.

Comment.—Ordinarily, in a case of this sort, as in a malpractice action, it must be established by medical expert testimony that the defendant physician was negligent and that his negligence was the proximate cause of the injury complained of (of the death of the patient in this case). In the absence of medical expert testimony, the plaintiff has failed to make a case and a nonsuit should be granted. In this case the plaintiff called four physicians to the stand, but would not have made a case for the jury except for the testimony of one of them. This gentleman was willing and anxious to condemn the defendant's conduct. That he was receiving a fee for testifying was not denied, and he also admitted that in the recent past he had had his license to practice suspended upon the charge of drug addiction.

Another of the plaintiff's medical witnesses who, unknown to the defendant, had been treating the decedent, testified that he had examined the decedent's throat upon the very day of the operation, that there was no infection, and that he was, himself, preparing the patient for tonsillectomy. Needless to say this testimony was a surprise and a shock to the plaintiff's attorney.

What targets medical men are for unjust accusations of this sort! It is as unfortunate as it is certain that the public interest suffers as a result.

' ' '

CASE 8.—Another obstetrical case. A border line contracted pelvis. The patient's average weight was about 86 pounds. It was considered that a caesarian section would probably be necessary. X-rays were taken to determine the question of disproportion. It was decided to give the patient a test of labor. She delivered a 6 lb., 2 oz. child, which was normal and breathed spontaneously. Low forceps were used and a double episiotomy was done. The perineal incisions became infected, and the scars remained tender, resulting in dyspareunia. The obstetrician was sued. The defendant's motion for a nonsuit was granted.

Comment.—A double episiotomy is unusual. The result in this case could be considered excellent. It is believed that had a consultant been called in there would have been no suit. The occurrence of a perineal infection caused the patient to lose confidence in her physician and, unfortunately, the physician next called in did nothing to restore it. On the contrary, he apparently suggested to the patient that she had been unfortunate in her first choice of physicians, but was finally in good hands. And, as coincidentally so regularly appears in such circumstances, the succeeding physician's bill was large.

' ' '

CASE 9.—A boy of 13 fell on the school grounds, injuring his right elbow. He was immediately taken to the defendant physician who diagnosed the injury as a backward dislocation of both bones of the forearm. No x-ray was taken at that time. Under evipal anesthesia, the arm was manipulated, and, according to the attending physician, the dislocation was reduced. The arm was put in the Jones position, held by adhesive tape. There was marked swelling about the elbow and some blebs formed and broke. However, the physician did not see the patient, according to plaintiff's testimony, until three days later, although the arm was let down to a right angle position across the chest on the day following the injury. This was done following the instructions of the doctor which were given over the telephone.

X-rays, made three days after the injury, disclosed that the joint was in good position, but that there was a frac-

ture of the median epicondyle with the fragment displaced downward to the level of the elbow joint, and a chip fracture of the lateral epicondyle. At this time there was numbness of the little and the medial half of the ring finger, and of the palm in the hypothenar area, and the little and ring fingers were drawn up in flexion to a ninety degree angle. At this time a moulded plaster splint was applied to the posterior aspect of the arm and forearm, holding the elbow at a right angle. Under the doctor's instructions, again over the telephone, the cast was removed by the parents of the patient about three weeks later, and thereafter the arm was carried in a sling. The doctor also gave instructions that the parts should be massaged daily, and that the patient should carry a "bucket of rocks" for some minutes three times daily. About three weeks later, evipal was again administered to the patient and the physician attempted to increase the motion in the joint by some forceful manipulation. This was unsuccessful.

One week later, the patient was placed in the charge of other physicians. X-rays taken at this time showed the fractures as disclosed in the only x-rays which had been made by the first attending physician, plus fairly marked myositis ossificans blocking flexion beyond 65° and extension beyond about 125°. Ulnar palsy was also diagnosed. At surgery, the displaced median epicondyle was removed and the ulnar nerve dissected free from scar tissue and transplanted anteriorly. The ulnar paralysis disappeared entirely during the next few weeks.

At the time of the trial of the malpractice action brought against the first attending physician, the limitation in motion remained about as indicated above. The experts generally agreed that further improvement could reasonably be expected to result from additional surgery. The jury brought in a verdict in favor of the plaintiff.

Comment.—This was a case in which the medico-legal advisers recommended settlement. The plaintiff had expressed a willingness to accept an amount which was only half as large as the judgment eventually obtained. Had such a settlement been made there would also, of course, have been a great saving in the way of legal expense.

While the entire course of care of the attending physician in this case might be criticised, the following four points should, from the angle of malpractice prophylaxis, be emphasized: (1) the importance of taking initial x-rays and sufficient x-rays thereafter; (2) the legal duty of giving sufficient care and attention, (it was claimed that this patient was seen only five times); (3) the desirability of having consultation protective both to the patient and the physician; and (4) the necessity, in the selection of patients, to accept only those that the physician is well qualified to care for.

* * *

CASE 10.—Intestinal obstruction caused by a constricting band developed in a woman at the time she was about four and one-half months pregnant. This was the patient's second pregnancy; three years before there had been an early abortion (curettage). Five years before, an appendectomy and a right oöphorectomy had been done. The current pregnancy was uneventful for four and a half months. Then, according to the history, following a meal of Mexican beans, the patient was nauseated and had abdominal cramps. She was hospitalized. There was considerable vomiting and some abdominal distention. The patient was treated conservatively. In the first twenty-four hours there was no bowel movement and the distention increased. During the next twenty-four hours there were five bowel movements and the distention markedly decreased. The patient was then allowed to go home. (The financial status of the family was a factor.)

The next evening, not being able immediately to reach the attending physician, and there having been a recurrence of symptoms, another physician was called in. (The first attending physician never saw the patient thereafter.) The patient was placed in another hospital, where she was given conservative treatment. After about twelve hours, because it was believed that surgery might be necessary, the patient was removed to a public hospital where, twenty-four hours later, an operation was performed. A constricting band of adhesions was found about the lower ileum. This was severed and an ileostomy done. The patient recovered, after a rather stormy convalescence. (The patient miscarried shortly after the operation.)

The first attending physician was sued on the theories: (1) that he had failed to use proper methods in making diagnosis, and for failure to diagnose the case as intestinal obstruction; (2) that he had failed to properly treat the patient.

The first attending physician's diagnosis, as disclosed by the hospital chart, was: (1) toxemia of pregnancy; (2) enteritis, acute; and (3) partial intestinal obstruction (?). Consultation was had. The consultant concurred in the diagnosis and approved the treatment. He also agreed that, in the circumstances, the patient might be allowed to go home, to return if necessary.

After fourteen days of trial the jury returned a unanimous verdict in favor of the defendant.

Comment.—The first succeeding physician in this case had been in practice only eleven months. His harsh and unjust criticism of his predecessor precipitated the malpractice claim. He did not contact the first physician to ascertain, at first hand, what the problem was or what had been done. He made a diagnosis of acute intestinal obstruction, complete, but nevertheless kept the patient in hospital for more than twelve hours while efforts were being made to effect necessary financial arrangements.

This case illustrates again that while a physician may be unjustly assailed, he can be in a position so that it is very unlikely that the plaintiff can prevail. In this case the defendant not only had taken good care of his patient but his records, office and hospital, were splendid and served to establish his defense. Furthermore he had had consultation at the critical moment.

* * *

These cases help to emphasize the whole point of this discussion, namely: that it is desirable to make our ethics practical for the sake of the patient, for the sake of our fellow practitioners, and for our own protection and satisfaction.

6777 Hollywood Boulevard.

We now demand to be personally conducted through life, all risks to be taken by someone else.

—Dean W. R. Inge. (Marchant, *Wit and Wisdom of Dean Inge.* No. 109.)